PREMIER UROLOGY GROUP, LLC

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PATIENT INFORMATION

NAME (Last, First Middle)	SSN#	MARITAL STATUS	SEX	BIRTHDATE	AGE

ADDRESS	CITY, STATE, ZIP	EMAIL ADDRESS

HOME PHONE	DAY PHONE	CELL PHONE

EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT	EMERGENCY CONTACT HOME PHONE	EMERGENCY CONTACT DAY PHONE

PRIMARY PHYSICIAN NAME	PRIMARY PHYSICIAN ADDRESS	PRIMARY PHYSICIAN PHONE NUMBER

HOW DID YOU HEAR ABOUT OUR PRACTICE? (PLEASE CHECK ONE)

☐ **Referred By Physician** ☐ **Facebook/Twitter** ☐ **Internet Search** ☐ **Insurance Company Website** ☐ **Other (Please explain):**

WHY ARE YOU SEEING THE DOCTOR TODAY?

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

ADDRESS	CITY, STATE ZIP	MARITAL STATUS	EMAIL ADDRESS

HOME PHONE	DAY PHONE	RELATIONSHIP TO PATIENT

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY #
ADDRESS OF INSURANCE COMPANY	GROUP #

CITY, STATE ZIP OF INSURANCE COMPANY	EFFECTIVE DATE OF INSURANCE	COPAY FOR SPECIALIST $

PHONE NUMBER OF INSURANCE COMPANY	NAME OF PERSON INSURED	BIRTHDATE OF PERSON INSURED	RELATIONSHIP TO PATIENT

SECONDARY INSURANCE (If Applicable)

NAME OF INSURANCE COMPANY	POLICY #
ADDRESS OF INSURANCE COMPANY	GROUP #

CITY, STATE ZIP OF INSURANCE COMPANY	EFFECTIVE DATE OF INSURANCE	COPAY FOR SPECIALIST $

PHONE NUMBER OF INSURANCE COMPANY	NAME OF PERSON INSURED	BIRTHDATE OF PERSON INSURED	RELATIONSHIP TO PATIENT

ASSIGNMENT OF BENEFITS: I irrevocably assign by right to payment from any insurance company/other payor of health benefits to Premier Urology Group, LLC for services furnished to me.
RELEASE OF INFORMATION: I understand that Premier Urology Group, LLC is entitled to release my medical and insurance information to any entity for the purpose of treatment, payment or operational purposes.
NOTICE OF CANCELLATION POLICY: Office appointments not cancelled at least 24 hours prior will be subject to the following fees: Visit w/o procedure: $25, Visit w/ procedure: $50, Consultation: $100, Vasectomy: $100. Hospital/Out Patient Facility procedures not cancelled at least 7 days prior will be subject to a $250 fee. These "Cancellation Fees" are not reimbursable by your insurance company.

____ ____________________________

SIGNATURE OF PATIENT/GUARDIAN DATE

Have you ever seen a urologist before? ____________ If so, why? ____

Please list any surgical procedures you have had ____

____

Have you ever received a blood transfusion? Yes __________________ No __________________

Do you have any allergies or bad reaction to any foods or drugs? Yes _________________ No _________________
(Particularly lobster, shellfish or drugs like penicillin)
IF YES, PLEASE SPECIFY: ____

Please circle any of the following conditions you currently have or have been treated for in the past:

High blood pressure	Diabetes	Tuberculosis	Heart Attack	Cancer	HIV
Thyroid Imbalance	Syphilis	Gonorrhea	Asthma	Gout	AIDS
Nervous Breakdown	Hepatitis	Glaucoma	Ulcers	Stroke	

Please list any medications you are presently taking:
Name Dosage

____

____

____

Pharmacy Information: Name ___________________________________ Phone _______________________________________

Pharmacy Address: ____
Do you take aspirin or other anti-inflammatory medication daily? Yes _____________No ______________
Do you have any pain of difficulty with urination? Yes _____________No ______________
Have you ever had a kidney infection? Yes _____________No ______________
Do you have any back pain? Yes _____________ No ______________
Have you had any chills or fever recently? Yes _____________ No _____________
Have you ever seen or been told there is blood in your urine? Yes _____________ No _____________
Have you ever had kidney stones? Yes _____________ No _____________
Have you ever been unable to urinate? Yes _____________ No _____________
How many times do you awaken at night to urinate? ____
How many times do you urinate during the day? ____
MEN: Do you have difficulty obtaining or maintaining an erection? Yes _____________ No ______________
WOMEN: When was your last menstrual period? ____

IMPORTANT NOTICE REGARDING REFERRALS
You may be referred to a laboratory or other facility by our physicians. Please note that you have the option to have your procedure done at any facility of your choice and are not obligated to utilize the facility to which you were referred.
IMPORTANT NOTICE
Please be advised that Medicare and/or you private health insurance carrier may not cover certain procedures or services that your doctor deems necessary for the complete evaluation and management of your care. This may include various ultrasound procedures, injections, diagnostic tests, etc. Please note that you may be responsible of any balance not paid by your insurance company.
Also, please be advised that if your insurance company requires a referral or authorization for any services or procedures performed it is YOUR responsibility to present a valid referral or authorization to this office PRIOR to services being rendered.

Current insurance regulations require that we notify you, the patient, of this situation prior to your treatment.

Patient Signature ____

Patient
Name____Date____

REVIEW OF SYSTEMS

Do you now have or had any problems related to the following systems? **Circle Yes or No**
Please explain any Yes Answers in the space provided.

Constitutional Symptoms
Fever Yes No
Chills Yes No
Headache Yes No
Other ______________________

Eyes
Blurred Vision Yes No
Double Vision Yes No
Pain Yes No
Other _______________________

Allergic/Immunologic
Hay Fever Yes No
Drug Allergies Yes No
Other _______________________

Neurological
Tremors Yes No
Dizzy Spells Yes No
Numbness/Tingling Yes No
Other ______________________

Endocrine
Excessive Thirst Yes No
Too Hot/Cold Yes No
Tired/Sluggish Yes No
Other ______________________

Gastrointestinal
Abdominal Pain Yes No
Nausea/Vomiting Yes No
Indigestion/Heartburn Yes No
Other _______________________

Cardiovascular
Chest Pain Yes No
Varicose Veins Yes No
High Blood Pressure Yes No

Integumentary
Skin Rash Yes No
Boils Yes No
Persistent Itch Yes No
Other _______________________

Musculoskeletal
Joint Pain Yes No
Neck Pain Yes No
Back Pain Yes No
Other _______________________

Ear/Nose/Throat/Mouth
Ear Infection Yes No
Sore Throat Yes No
Sinus Problems Yes No
Other _______________________

Genitourinary
Urine Retention Yes No
Painful Urination Yes No
Urinary Frequency Yes No
Other _______________________

Respiratory
Wheezing Yes No
Frequent Cough Yes No
Shortness of Breath Yes No
Other _______________________

Hematologic/Lymphatic
Swollen Glands Yes No
Blood Clotting Problem Yes No
Other _______________________

Psychologic
Are you generally satisfied with your life? Yes No
Do you feel severely depressed? Yes No
Have you ever considered suicide? Yes No
Other _______________________

Family History:

Mother __________ Diabetes Heart Disease Cancer ________________
(Age at death, if deceased)

Father __________ Diabetes Heart Disease Cancer

Prostate Cancer ________________
(Age at death, if deceased)

List significant sibling diseases (brothers/sisters)

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Premier Urology Group, LLC
DISCLOSURE FORM

Dear Patient:
Public Law of the State of New Jersey mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners must inform patients of any significant financial interest in a health care service to which they refer their patients. The purpose of this notice is to advise you that Premier Urology Group, LLC, which is the medical practice of which your treating urologist is a member, operates its own anatomic pathology laboratory. In addition, your physician may have a financial interest in one or more of the following facilities to which our patients may be referred:

THE AMBULATORY CENTER FOR SURGERY
Mountainside, NJ

THE STONE CENTER OF NEW JERSEY
Newark, NJ

THE SHORT HILLS SURGERY CENTER
Millburn, NJ

PREMIER UROLOGY GROUP, LLC
RADIATION ONCOLOGY
Cranford, NJ

As our patient you may require, at some time, a urological procedure to be performed at one of our facilities which may result in the need to have certain tissue samples tested at an anatomic pathology laboratory. To the extent your physician determines that anatomic pathology laboratory tests are necessary, Premier Urology Group, LLC will provide such tests through its own anatomic laboratory and will bill you separately from any bill issued by the facility where the urological procedure is performed.
By signing this disclosure you or your legal representative, acknowledge that: (1) you have been informed of the financial interests of the practitioners in this office.

Understood and agreed:

Patient Signature:

Witness:

____
Printed Name

____
Printed Name

___________________________, 20____
Date

______________________________, 20____
Date

Complaints may be lodged with the following:
N.J. Department of Health and Senior Services
Division of Health Facilities Evaluation and Licensing
PO Box 367
Trenton, NJ 08625-0367
Complaint Hotline: 1-800-792-9770
http://www.state.nj.us/health/healthfacilities
and/or
Office of the Medicare Beneficiary Ombudsman
http://www.medicare.gov/Ombudsman/activities.asp

PREMIER
UROLOGY GROUP, LLC
Consultants in Urology Division

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ANDREW J. BERNSTEIN, M.D.

DIPLOMATES
AMERICAN BOARD OF UROLOGY

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

By signing this authorization, I authorize Premier Urology Group, LLC to disclose certain protected health information (PHI) to the party or parties listed below.
This authorization permits Premier Urology Group, LLC to disclose to:
(Please note relative, friend or other person to whom we may disclose information)

1. ______________________________ ____________________ ________________
Last Name, First Name Contact Phone Number Relationship to Patient

2. ______________________________ ____________________ ________________
Last Name, First Name Contact Phone Number Relationship to Patient

3. ______________________________ ____________________ ________________
Last Name, First Name Contact Phone Number Relationship to Patient

I have the right to revoke this authorization in writing except to the extent that Premier Urology Group, LLC has acted in reliance upon this authorization. My written revocation must be submitted to Premier Urology Group, LLC, Privacy Officer at 570 South Avenue East, Bldg. A, Cranford, NJ 07016

Signed by: ______________________________ ______________________
Signature of Patient or Legal Guardian Relationship to Patient

______________________________ ______________________
Patient's Name, Printed Date

______________________________ ______________________
Patient's Date of Birth Patient's Social Security Number 02/18/16/dp

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